FOR OHF USE

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0035618

Facility Name: BRYN MAWR CARE INC.

Address: 5547 NORTH KENMORE (Number) CHICAGO (City) 60640 (Zip Code)

County: COOK

Telephone Number: (773) 561-7040 **Fax #** (773) 561-7543

IDPA ID Number: 363654908001

Date of Initial License for Current Owners: 08/01/89

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name:: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/02 to 12/31/02 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) _____

(Title) _____

Paid Preparer

(Signed) See Accountants' Compilation Report Attached (Date)

(Print Name and Title) CARY C. BUXBAUM, C.P.A.

(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015

(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BRYN MAWR CARE INC. # 0035618 Report Period Beginning: 01/01/02 Ending: 12/31/02

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	174	Intermediate (ICF)	174	63,510	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	174	TOTALS	174	63,510	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	59,843	927	32	60,802	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	59,843	927	32	60,802	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.74%

D. How many bed-hold days during this year were paid by Public Aid?
1,178 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 8/1/89

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 8/1/89 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/02 Fiscal Year: 12/31/02

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number BRYN MAWR CARE INC. # 0035618 Report Period Beginning: 01/01/02 Ending: 12/31/02

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	136,530	12,125	29,748	178,403		178,403	(16,900)	161,503			1
2	Food Purchase		216,179		216,179	(14,053)	202,127	(33)	202,094			2
3	Housekeeping	107,221	13,696		120,917		120,917	580	121,497			3
4	Laundry		10,055		10,055		10,055		10,055			4
5	Heat and Other Utilities			79,776	79,776		79,776	1,935	81,711			5
6	Maintenance	42,051	8,022	94,149	144,222		144,222	(35,716)	108,506			6
7	Other (specify):*							6,459	6,459			7
8	**TOTAL General Services**	285,802	260,077	203,673	749,552	(14,053)	735,500	(43,675)	691,825			8
	B. Health Care and Programs											
9	Medical Director			2,400	2,400		2,400		2,400			9
10	Nursing and Medical Records	836,761	16,679	88,415	941,855		941,855	(17,030)	924,825			10
10a	Therapy	29,589		15,456	45,045		45,045	(4,140)	40,905			10a
11	Activities	121,464	6,345	2,033	129,842		129,842		129,842			11
12	Social Services	210,757		1,800	212,557		212,557		212,557			12
13	Nurse Aide Training											13
14	Program Transportation			505	505		505		505			14
15	Other (specify):*							6,284	6,284			15
16	**TOTAL Health Care and Programs**	1,198,571	23,024	110,609	1,332,204		1,332,204	(14,886)	1,317,318			16
	C. General Administration											
17	Administrative	69,163		349,054	418,217		418,217	(241,458)	176,759			17
18	Directors Fees											18
19	Professional Services			142,521	142,521	(337)	142,184	(84,186)	57,998			19
20	Dues, Fees, Subscriptions & Promotions			22,630	22,630		22,630	(8,619)	14,011			20
21	Clerical & General Office Expenses	58,341	17,229	49,908	125,478		125,478	29,028	154,506			21
22	Employee Benefits & Payroll Taxes			275,243	275,243	14,053	289,296		289,296			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,236	1,236		1,236	238	1,474			24
25	Other Admin. Staff Transportation			1,908	1,908		1,908	2,395	4,303			25
26	Insurance-Prop.Liab.Malpractice			96,628	96,628		96,628	1,010	97,638			26
27	Other (specify):*							27,644	27,644			27
28	**TOTAL General Administration**	127,504	17,229	939,128	1,083,861	13,716	1,097,577	(273,948)	823,629			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,611,877	300,330	1,253,410	3,165,617	(337)	3,165,280	(332,508)	2,832,772			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number BRYN MAWR CARE INC. #0035618 Report Period Beginning: 01/01/02 Ending: 12/31/02

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			63,668	63,668		63,668	97,243	160,911			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			2,912	2,912		2,912	421,942	424,854			32
33	Real Estate Taxes			106,039	106,039	337	106,376	5,281	111,657			33
34	Rent-Facility & Grounds			575,880	575,880		575,880	(575,880)				34
35	Rent-Equipment & Vehicles			6,125	6,125		6,125	6,449	12,574			35
36	Other (specify):*							8,548	8,548			36
37	**TOTAL Ownership**			754,624	754,624	337	754,961	(36,417)	718,544			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			95,265	95,265		95,265		95,265			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			95,265	95,265		95,265		95,265			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,611,877	300,330	2,103,299	4,015,506		4,015,506	(368,925)	3,646,581			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BRYN MAWR CARE INC. # 0035618 Report Period Beginning: 01/01/02 Ending: 12/31/02

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	51,145	30		9
10	Interest and Other Investment Income	(2,912)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(33)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(3,250)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(5,402)	21		24
25	Fund Raising, Advertising and Promotional	(2,860)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(40,755)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (4,067)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(364,858)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (364,858)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (368,925)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

BRYN MAWR CARE INC.

ID# 0035618

Report Period Beginning: 01/01/02

Ending: 12/31/02

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Miscellaneous Income - Jury Duty	$ (120)	10	1
2	Miscellaneous Income - Phone Rent	(433)	35	2
3	COPE Dues	(2,725)	20	3
4	Veterans Expense	(30)	10	4
5	State Replacement Tax	(16,855)	21	5
6	Contributions (Bldg. Co.)	(500)	20	6
7	Capitalized Repairs & Maintenance	(20,092)	6	7
8				8
9				9
10				10
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99				99
100				100
101	Total	(40,755)		101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number BRYN MAWR CARE INC. # 0035618 Report Period Beginning: 01/01/02 Ending: 12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary					(16,900)							(16,900)	1
2	Food Purchase	(33)											(33)	2
3	Housekeeping			580									580	3
4	Laundry													4
5	Heat and Other Utilities			729	1,206								1,935	5
6	Maintenance	(20,092)		514	(9,657)	(6,481)							(35,716)	6
7	Other (specify):*				915	5,544							6,459	7
8	**TOTAL General Services**	(20,125)		1,823	(7,536)	(17,837)							(43,675)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(150)			(15,457)			(1,423)					(17,030)	10
10a	Therapy					(4,140)							(4,140)	10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*				3,938	2,346							6,284	15
16	**TOTAL Health Care and Programs**	(150)			(11,519)	(1,794)		(1,423)					(14,886)	16
	C. General Administration													
17	Administrative			13,417	(52,824)	(197,563)			(4,488)				(241,458)	17
18	Directors Fees													18
19	Professional Services			(81,109)	(9,524)	6,413			34				(84,186)	19
20	Fees, Subscriptions & Promotions	(9,335)	500	179	17				20				(8,619)	20
21	Clerical & General Office Expenses	(22,257)		44,887	6,232				166				29,028	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			35	203								238	24
25	Other Admin. Staff Transportation			526	1,869								2,395	25
26	Insurance-Prop.Liab.Malpractice			393	617								1,010	26
27	Other (specify):*			8,703	5,418	13,257			266				27,644	27
28	**TOTAL General Administration**	(31,592)	500	(12,969)	(47,992)	(177,893)			(4,002)				(273,948)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(51,867)	500	(11,146)	(67,047)	(197,524)		(1,423)	(4,002)				(332,508)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number BRYN MAWR CARE INC. # 0035618 **Report Period Beginning:** 01/01/02 **Ending:** 12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	51,145	41,189	1,912	2,997								97,243	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(2,912)	420,446	972	3,436								421,942	32
33	Real Estate Taxes			1,723	3,558								5,281	33
34	Rent-Facility & Grounds		(575,880)										(575,880)	34
35	Rent-Equipment & Vehicles	(433)		2,605	4,277								6,449	35
36	Other (specify):*		8,548										8,548	36
37	**TOTAL Ownership**	47,800	(105,697)	7,212	14,268								(36,417)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	**TOTAL Special Cost Centers**													44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(4,067)	(105,197)	(3,934)	(52,779)	(197,524)		(1,423)	(4,002)				(368,925)	45

Facility Name & ID Number BRYN MAWR CARE INC. # 0035618 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES

A. **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.**

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental Income	$ 575,880	Bryn Mawr Care, LLC		$	$ (575,880)	1
2	V	34	Rental Income-R/E Taxes	106,039	Bryn Mawr Care, LLC			(106,039)	2
3	V	32	Interest Income	63	Bryn Mawr Care, LLC			(63)	3
4	V	34	Real Estate Tax		Bryn Mawr Care, LLC		106,039	106,039	4
5	V	36	Amortization-Nomura Fees		Bryn Mawr Care, LLC		8,548	8,548	5
6	V	30	Depreciation		Bryn Mawr Care, LLC		41,189	41,189	6
7	V	32	Mortgage Interest		Bryn Mawr Care, LLC		420,509	420,509	7
8	V	20	Contributions		Bryn Mawr Care, LLC		500	500	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 681,982			$ 576,785	$ * (105,197)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BRYN MAWR CARE INC. # 0035618 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	3	HOUSEKEEPING	$	PREFERRED BOOKKEEPING	100.00%	$ 580	$ 580	15
16	V	5	UTILITIES		PREFERRED BOOKKEEPING	100.00%	729	729	16
17	V	6	REPAIRS AND MAINT.		PREFERRED BOOKKEEPING	100.00%	514	514	17
18	V	17	ADMIN. FINANCIAL SAL.		PREFERRED BOOKKEEPING	100.00%	13,417	13,417	18
19	V	19	PROFESSIONAL FEES		PREFERRED BOOKKEEPING	100.00%	2,079	2,079	19
20	V	20	DUES,SUBSCRIPTIONS		PREFERRED BOOKKEEPING	100.00%	179	179	20
21	V	21	CLERICAL		PREFERRED BOOKKEEPING	100.00%	44,887	44,887	21
22	V	24	SEMINARS		PREFERRED BOOKKEEPING	100.00%	35	35	22
23	V	25	ADMIN. STAFF TRAVEL		PREFERRED BOOKKEEPING	100.00%	526	526	23
24	V	26	INSURANCE		PREFERRED BOOKKEEPING	100.00%	393	393	24
25	V	27	EMPLOYEE BENEFITS		PREFERRED BOOKKEEPING	100.00%	8,703	8,703	25
26	V	30	DEPRECIATION		PREFERRED BOOKKEEPING	100.00%	1,912	1,912	26
27	V	32	INTEREST		PREFERRED BOOKKEEPING	100.00%	972	972	27
28	V	33	REAL ESTATE TAXES		PREFERRED BOOKKEEPING	100.00%	1,723	1,723	28
29	V	35	EQUIPMENT RENTAL		PREFERRED BOOKKEEPING	100.00%	2,605	2,605	29
30	V								30
31	V								31
32	V	19	ACCOUNT./BOOKKEEPING	83,188	PREFERRED BOOKKEEPING	100.00%		(83,188)	32
33	V	19	COMPUTER	4,176	PREFERRED BOOKKEEPING	100.00%	4,176		33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 87,364			$ 83,430	$ * (3,934)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BRYN MAWR CARE INC. # 0035618 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	S.I.R. MANAGEMENT, INC.	100.00%	$ 1,206	$ 1,206	15
16	V	6	REPAIRS AND MAINT.	15,660	S.I.R. MANAGEMENT, INC.	100.00%	6,003	(9,657)	16
17	V	7	EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	915	915	17
18	V	10	NURSING	34,452	S.I.R. MANAGEMENT, INC.	100.00%	18,995	(15,457)	18
19	V	15	EMP. BEN.-H.C.		S.I.R. MANAGEMENT, INC.	100.00%	3,938	3,938	19
20	V	17	ADMINISTRATIVE	61,068	S.I.R. MANAGEMENT, INC.	100.00%	8,244	(52,824)	20
21	V	19	PROFESSIONAL FEES	14,100	S.I.R. MANAGEMENT, INC.	100.00%	4,576	(9,524)	21
22	V	20	FEES,SUBSCRIPTIONS		S.I.R. MANAGEMENT, INC.	100.00%	17	17	22
23	V	21	CLERICAL & GENERAL	17,748	S.I.R. MANAGEMENT, INC.	100.00%	23,980	6,232	23
24	V	24	EDUCATION & SEMINAR		S.I.R. MANAGEMENT, INC.	100.00%	203	203	24
25	V	25	OTHER ADMIN. STAFF TRANS.		S.I.R. MANAGEMENT, INC.	100.00%	1,869	1,869	25
26	V	26	INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	617	617	26
27	V	27	EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	5,418	5,418	27
28	V	30	DEPRECIATION		S.I.R. MANAGEMENT, INC.	100.00%	2,997	2,997	28
29	V	32	INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	3,436	3,436	29
30	V	33	REAL ESTATE TAXES		S.I.R. MANAGEMENT, INC.	100.00%	3,558	3,558	30
31	V	35	EQUIPMENT RENTAL		S.I.R. MANAGEMENT, INC.	100.00%	4,277	4,277	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 143,028			$ 90,249	$ * (52,779)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BRYN MAWR CARE INC. # 0035618 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY SALARIES	$ 17,748	S.I.R. MANAGEMENT, INC.	100.00%	$ 6,001	$ (11,747)	15
16	V	7	EMP. BEN.-DIETARY		S.I.R. MANAGEMENT, INC.	100.00%	1,244	1,244	16
17	V	17	ADMIN./LEGAL SALARIES	266,386	S.I.R. MANAGEMENT, INC.	100.00%	37,612	(228,774)	17
18	V	19	FINANCIAL CONSULTANT		S.I.R. MANAGEMENT, INC.	100.00%	12,677	12,677	18
19	V	27	EMP. BEN.-ADMINISTRATIVE		S.I.R. MANAGEMENT, INC.	100.00%	6,419	6,419	19
20	V								20
21	V	17	ADMIN. SALARY		S.I.R. MANAGEMENT, INC.	100.00%	24,707	24,707	21
22	V	27	EMP. BEN.-ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	3,966	3,966	22
23	V								23
24	V	17	ADMIN SALARY		S.I.R. MANAGEMENT, INC.	100.00%	19,104	19,104	24
25	V	27	EMP. BEN.-ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	2,872	2,872	25
26	V								26
27	V	10A	SPECIAL REHAB	15,456	S.I.R. MANAGEMENT, INC.	100.00%	11,316	(4,140)	27
28	V	15	EMP. BEN.-HEALTH CARE & PROG.		S.I.R. MANAGEMENT, INC.	100.00%	2,346	2,346	28
29	V								29
30	V	6	REPAIRS AND MAINT.	20,376	S.I.R. MANAGEMENT, INC.	100.00%	13,895	(6,481)	30
31	V	7	EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	2,881	2,881	31
32	V								32
33	V	1	DIETICIAN SALARIES	12,000	S.I.R. MANAGEMENT, INC.	100.00%	6,847	(5,153)	33
34	V	7	EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	1,419	1,419	34
35	V								35
36	V	19	LEGAL FEES	6,264	S.I.R. MANAGEMENT, INC.	100.00%		(6,264)	36
37	V								37
38	V	17	COUNCIL DUES	12,600	S.I.R. MANAGEMENT, INC.	100.00%		(12,600)	38
39	Total			$ 350,830			$ 153,306	$ * (197,524)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BRYN MAWR CARE INC. # 0035618 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	EMPLOYEE HEALTH INS.	$	CCS EMPLOYEE BENEFIT GROUP	100.00%	$ 89,515	$ 89,515	15
16	V								16
17	V								17
18	V								18
19	V	22	EMPLOYEE HEALTH INS.	89,515	CCS EMPLOYEE BENEFIT GROUP	100.00%		(89,515)	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 89,515			$ 89,515	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BRYN MAWR CARE INC. # 0035618 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietary	$	XCEL Medical Supply, LLC	100.00%	$	$	15
16	V	03	Housekeeping		XCEL Medical Supply, LLC	100.00%			16
17	V	10	Nursing	10,505	XCEL Medical Supply, LLC	100.00%	9,082	(1,423)	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 10,505			$ 9,082	$ * (1,423)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BRYN MAWR CARE INC. # 0035618 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	PROFESSIONAL FEES	$	ECM OWNERS COUNCIL	100.00%	$ 34	$ 34	15
16	V	20	DUES, FEES & SUBSCRIPTIONS		ECM OWNERS COUNCIL	100.00%	20	20	16
17	V	21	CLERICAL		ECM OWNERS COUNCIL	100.00%	166	166	17
18	V	17	MANAGEMENT FEES	9,000	ECM OWNERS COUNCIL	100.00%		(9,000)	18
19	V	17	ADMIN. SAL. - M. GIANNINI		ECM OWNERS COUNCIL	100.00%	4,512	4,512	19
20	V	27	EMP. BEN. - M. GIANNINI		ECM OWNERS COUNCIL	100.00%	266	266	20
21	V	17	ADMIN. SALARY		ECM OWNERS COUNCIL	100.00%			21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 9,000			$ 4,998	$ * (4,002)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BRYN MAWR CARE INC. # 0035618 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BRYN MAWR CARE INC. # 0035618 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BRYN MAWR CARE INC. # 0035618 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BRYN MAWR CARE INC. # 0035618 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Bryan Barrish	Stockholder	Administrative	4.89%	See Attached	5.21	14.88%	Alloc. Salary	$ 24,707	17-7	1
2	Mike Giannini	Stockholder	Administrative	2.88%	See Attached	5.95	14.88%	Alloc. Salary	23,616	17-7	2
3	Arturo Rominiquit	Relative	Clerical		See Attached	3.25	8.86%	Alloc. Salary	2,097	21-7	3
4	Nenita Guzman	Relative	Dietary		See Attached	4.84	9.68%	Alloc. Salary	6,001	1-7	4
5	Eric Rothner	Stockholder	Administrative	55.75%	See Attached	0.61	0.85%	Alloc. Salary	1,706	17-7	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 58,127		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number BRYN MAWR CARE INC. # 0035618 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BRYN MAWR CARE INC. # 0035618 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: PREFERRED BOOKEEPING SERVICES
Street Address: 4100 WEST PRATT AVE.
City / State / Zip Code: LINCOLNWOOD, IL. 60712
Phone Number: (847) 674-5200
Fax Number: (847) 674-5267

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	HOUSEKEEPING	BOOK./ACCNT.INCOME	938,058	11	$ 6,541	$	83,188	$ 580	1
2	5	UTILITIES	BOOK./ACCNT.INCOME	938,058	11	8,219		83,188	729	2
3	6	REPAIRS AND MAINT.	BOOK./ACCNT.INCOME	938,058	11	5,799		83,188	514	3
4	17	ADMIN. FINANCIAL SAL.	BOOK./ACCNT.INCOME	938,058	11	151,295	151,295	83,188	13,417	4
5	19	PROFESSIONAL FEES	BOOK./ACCNT.INCOME	938,058	11	23,448		83,188	2,079	5
6	20	DUES,SUBSCRIPTIONS	BOOK./ACCNT.INCOME	938,058	11	2,020		83,188	179	6
7	21	CLERICAL	BOOK./ACCNT.INCOME	938,058	11	506,159	442,988	83,188	44,887	7
8	24	SEMINARS	BOOK./ACCNT.INCOME	938,058	11	400		83,188	35	8
9	25	ADMIN. STAFF TRAVEL	BOOK./ACCNT.INCOME	938,058	11	5,937		83,188	526	9
10	26	INSURANCE	BOOK./ACCNT.INCOME	938,058	11	4,435		83,188	393	10
11	27	EMPLOYEE BENEFITS	BOOK./ACCNT.INCOME	938,058	11	98,137		83,188	8,703	11
12	30	DEPRECIATION	BOOK./ACCNT.INCOME	938,058	11	21,566		83,188	1,912	12
13	32	INTEREST	BOOK./ACCNT.INCOME	938,058	11	10,965		83,188	972	13
14	33	REAL ESTATE TAXES	BOOK./ACCNT.INCOME	938,058	11	19,425		83,188	1,723	14
15	35	EQUIPMENT RENTAL	BOOK./ACCNT.INCOME	938,058	11	29,379		83,188	2,605	15
16										16
17										17
18										18
19	19	COMPUTER	DIRECT ALLOCATION						4,176	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 893,725	$ 594,283		$ 83,430	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BRYN MAWR CARE INC. # 0035618 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: S.I.R. MANAGEMENT, INC.
Street Address: 6840 N. LINCOLN
City / State / Zip Code: LINCOLNWOOD, IL. 60712
Phone Number: (847) 675 -7979
Fax Number: (847) 675 -0555

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	PATIENT DAYS	628,177	10	$ 12,461	$	60,802	$ 1,206	1
2	6	REPAIRS AND MAINT.	PATIENT DAYS	628,177	10	62,016	45,622	60,802	6,003	2
3	7	EMP. BEN.-GEN. SERV.	PATIENT DAYS	628,177	10	9,458		60,802	915	3
4	10	NURSING	PATIENT DAYS	628,177	10	196,243	196,243	60,802	18,995	4
5	15	EMP. BEN.-H.C.	PATIENT DAYS	628,177	10	40,682		60,802	3,938	5
6	17	ADMINISTRATIVE	PATIENT DAYS	628,177	10	85,174	85,174	60,802	8,244	6
7	19	PROFESSIONAL FEES	PATIENT DAYS	628,177	10	47,273		60,802	4,576	7
8	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	628,177	10	176		60,802	17	8
9	21	CLERICAL & GENERAL	PATIENT DAYS	628,177	10	247,745	202,804	60,802	23,980	9
10	24	EDUCATION & SEMINAR	PATIENT DAYS	628,177	10	2,093		60,802	203	10
11	25	OTHER ADMIN. STAFF TRANS	PATIENT DAYS	628,177	10	19,306		60,802	1,869	11
12	26	INSURANCE	PATIENT DAYS	628,177	10	6,377		60,802	617	12
13	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	628,177	10	55,976		60,802	5,418	13
14	30	DEPRECIATION	PATIENT DAYS	628,177	10	30,963		60,802	2,997	14
15	32	INTEREST	PATIENT DAYS	628,177	10	35,501		60,802	3,436	15
16	33	REAL ESTATE TAXES	PATIENT DAYS	628,177	10	36,759		60,802	3,558	16
17	35	EQUIPMENT RENTAL	PATIENT DAYS	628,177	10	44,185		60,802	4,277	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 932,388	$ 529,843		$ 90,249	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BRYN MAWR CARE INC. # 0035618 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: S.I.R. MANAGEMENT, INC.
Street Address: 6840 N. LINCOLN
City / State / Zip Code: LINCOLNWOOD, IL. 60712
Phone Number: (847) 675 -7979
Fax Number: (847) 675 -0555

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY SALARIES	PATIENT DAYS	628,177	10	$ 62,004	$ 62,004	60,802	$ 6,001	1
2	7	EMP. BEN.-DIETARY	PATIENT DAYS	628,177	10	12,854		60,802	1,244	2
3	17	ADMIN./LEGAL SALARIES	PATIENT DAYS	628,177	10	388,593	388,593	60,802	37,612	3
4	19	FINANCIAL CONSULTANT	PATIENT DAYS	628,177	10	130,972		60,802	12,677	4
5	27	EMP. BEN.-ADMINISTRATIVE	PATIENT DAYS	628,177	10	$ 66,321	$	60,802	$ 6,419	5
6										6
7	17	ADMIN. SALARY	AVG HRS WKD	35	10	165,979	165,979	5	24,707	7
8	27	EMP. BEN.-ADMIN.	AVG HRS WKD	35	10	26,644		5	3,966	8
9						$	$		$	9
10	17	ADMIN SALARY	AVG HRS WKD	40	10	128,429	128,429	6	19,104	10
11	27	EMP. BEN.-ADMIN.	AVG HRS WKD	40	10	19,310		6	2,872	11
12										12
13	10A	SPECIAL REHAB	SPECIAL REHAB INC.	82,944	4	$ 60,726	$ 60,726	15,456	$ 11,316	13
14	15	EMP. BEN.-HEALTH CARE & P	SPECIAL REHAB INC.	82,944	4	12,589		15,456	2,346	14
15										15
16	6	REPAIRS AND MAINT.	MAINTENANCE INC.	177,156	10	120,809	120,809	20,376	13,895	16
17	7	EMP. BEN.-GEN. SERV.	MAINTENANCE INC.	177,156	10	25,044		20,376	2,881	17
18										18
19	1	DIETICIAN SALARIES	DIETICIAN SERVICE INC.	125,400	10	71,551	71,551	12,000	6,847	19
20	7	EMP. BEN.-GEN. ADMIN.	DIETICIAN SERVICE INC.	125,400	10	14,833		12,000	1,419	20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,306,658	$ 998,091		$ 153,306	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BRYN MAWR CARE INC. # 0035618 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CCS EMPLOYEE BENEFITS GROUP, INC.
Street Address: 4101 W. MAIN ST.
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847) 674-1180
Fax Number: (847) 673-7741

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	EMPLOYEE HEALTH INS.	DIRECT ALLOCATION			$	$		$ 89,515	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 89,515	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BRYN MAWR CARE INC. # 0035618 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: XCEL MEDICAL SUPPLY, LLC
Street Address: 2201 MAIN STREET
City / State / Zip Code: EVANSTON, IL 60202
Phone Number: (847)328-7600
Fax Number: (847)3287615

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	Dietary	Direct Allocation			$	$		$	1
2	03	Housekeeping	Direct Allocation							2
3	10	Nursing	Direct Allocation						9,082	3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 9,082	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BRYN MAWR CARE INC. # 0035618 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: ECM OWNERS COUNCIL
Street Address: 6840 N. LINCOLN
City / State / Zip Code: LINCOLNWOOD, IL. 60646
Phone Number: (847) 676-2026
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	PROFESSIONAL FEES	ECMOC MGMNT FEE INC.	40,000	9	$ 150	$	9,000	$ 34	1
2	20	DUES, FEES & SUBSCRIPTION	ECMOC MGMNT FEE INC.	40,000	9	89		9,000	20	2
3	21	CLERICAL	ECMOC MGMNT FEE INC.	40,000	9	739		9,000	166	3
4	17	MANAGEMENT FEES	ECMOC MGMNT FEE INC.	40,000	9			9,000		4
5	17	ADMIN. SAL. - M. GIANNINI	ADMIN. HOURS	38	9	29,045	29,045	6	4,512	5
6	27	EMP. BEN. - M. GIANNINI	ADMIN. HOURS	38	9	1,713		6	266	6
7	17	ADMIN. SALARY	DIRECT ALLOCATION		7	(2,635)				7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 29,101	$ 29,045		$ 4,998	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BRYN MAWR CARE INC. # 0035618 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BRYN MAWR CARE INC. # 0035618 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BRYN MAWR CARE INC. # 0035618 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BRYN MAWR CARE INC. # 0035618 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Nomura		X	Mortgage	$42,679.00	03/01/96	$ 5,217,000	$ 4,728,212	02/01/21	8.69%	$ 420,509	1
2												2
3												3
4												4
5												5
	Working Capital											
6			X	Insurance Financing							2,912	6
7												7
8												8
9	TOTAL Facility Related				$42,679.00		$ 5,217,000	$ 4,728,212			$ 423,421	9
	B. Non-Facility Related*											
10	See Supplemental Schedule										4,408	10
11	Interest Income										(2,912)	11
12	Interest Income-Bldg. Co.										(63)	12
13												13
14	TOTAL Non-Facility Related						$	$			$ 1,433	14
15	TOTALS (line 9+line14)						$ 5,217,000	$ 4,728,212			$ 424,854	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number BRYN MAWR CARE INC. # 0035618 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1	Allocated-Preferred Bkkp.	X					$	$			$ 972	1
2	Allocated-SIR Management	X									3,436	2
3												3
4												4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							$	$			$ 4,408	21

Facility Name & ID Number BRYN MAWR CARE INC. # 0035618 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2001 report.	$	103,800	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	108,620	2
3. Under or (over) accrual (line 2 minus line 1).	$	4,820	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)	$	106,500	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$	337	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	111,657	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1997	111,190	8
1998	113,164	9
1999	107,001	10
2000	100,719	11
2001	103,339	12

2002 Accrual = $103,330 X estimated 3% increase = $106,500

Allocated SIR Properties-SIR Management $3558

Allocated SIR Properties-Preferred Bookkeeping $1723

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME BRYN MAWR CARE INC. COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0035618

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	14-08-202-002	Long Term Care Property	$ 99,703.32	$ 99,703.32
2.	14-08-202-003	Long Term Care Property	$ 3,635.62	$ 3,635.62
3.	See Attached	SIR Management Allocation	$ 69,233.82	$ 4,597.91
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 172,572.76	$ 107,936.85

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME BRYN MAWR CARE INC. COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0035618

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number BRYN MAWR CARE INC. # 0035618 Report Period Beginning: 01/01/02 Ending: 12/31/02

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 39,120 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories 6

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

NONE

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	FACILITY		1989	$ 63,070	1
2					2
3	TOTALS			$ 63,070	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BRYN MAWR CARE INC. # 0035618 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4				1989	$ 1,443,623	$ 41,189	35	$ 41,246	$ 57	$ 553,384	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1989	3,323		20	133	133	1,762	9
10	Various			1990	21,607		20	1,032	1,032	12,943	10
11	Various			1991	99,075		20	4,955	4,955	56,298	11
12	Various			1992	37,297		20	1,865	1,865	20,105	12
13	Various			1993	18,516		20	853	853	9,800	13
14	Various			1994	33,458		20	2,429	2,429	20,352	14
15	Various			1995	64,419		20	3,497	3,497	26,398	15
16	Various			1996	130,280		20	6,513	6,513	42,487	16
17	Various			1997	192,708		20	9,997	9,997	51,978	17
18	Various			1998	163,775		20	8,189	8,189	37,131	18
19								-		-	19
20								-		-	20
21								-		-	21
22								-		-	22
23								-		-	23
24								-		-	24
25								-		-	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

See Page 12A, Line 70 for total

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BRYN MAWR CARE INC. # 0035618 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$ -	$	$ -	37
38						-		-	38
39						-		-	39
40						-		-	40
41						-		-	41
42						-		-	42
43						-		-	43
44						-		-	44
45						-		-	45
46						-		-	46
47						-		-	47
48						-		-	48
49						-		-	49
50						-		-	50
51						-		-	51
52						-		-	52
53						-		-	53
54						-		-	54
55						-		-	55
56						-		-	56
57						-		-	57
58						-		-	58
59						-		-	59
60						-		-	60
61						-		-	61
62						-		-	62
63						-		-	63
64						-		-	64
65						-		-	65
66						-		-	66
67						-		-	67
68	Related Party Allocations (Page 12-REP & Page 12A-REP)		76,735	2,757		3,015	258	22,870	68
69	Financial Statement Depreciation			15,289			(15,289)		69
70	TOTAL (lines 4 thru 69)		$ 2,284,816	$ 59,235		$ 83,724	$ 24,489	$ 855,508	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BRYN MAWR CARE INC. # 0035618 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 2,284,816	$ 59,235		$ 83,724	$ 24,489	$ 855,508	1
2	SIR MGMT ALLOC	1999	9,735		20	487	487	1,623	2
3	FIRE DOORS (22)	1999	29,826		20	1,491	1,491	4,597	3
4	WINDOWS	2000	99,727		20	4,986	4,986	14,543	4
5	WATER HEATER	2000	4,100		20	205	205	444	5
6	A/C WORK	2000	3,360		20	168	168	406	6
7	DOOR MONITORING	2000	2,199		20	110	110	255	7
8	ELECTRIC WIRING	2000	1,046		20	52	52	118	8
9	ELECTRICAL	2000	5,702		20	285	285	594	9
10	ROOF	2000	4,300		20	215	215	448	10
11	PLUMBING WORK	2001	7,990		20	400	400	800	11
12	LOBBY HVAC	2001	4,320		20	216	216	342	12
13	LIGHTING	2001	5,408		20	270	270	405	13
14	WATER RISER	2001	6,858		20	343	343	515	14
15	FLOORING	2001	22,758		20	2,276	2,276	3,414	15
16	FLOORING	2001	2,128		20	106	106	159	16
17	ELEVATOR WORK	2001	5,690		20	285	285	404	17
18	ELEVATOR CABLES	2001	7,750		20	388	388	485	18
19	N. STATION WORK	2001	31,472		20	1,574	1,574	1,836	19
20	BLINDS	2001	6,183		20	309	309	361	20
21	TILING	2001	949		20	47	47	55	21
22	ROOFING	2001	2,890		20	145	145	290	22
23	DOWNSPOUT	2001	2,670		20	134	134	257	23
24	TUCKPOINTING	2001	2,500		20	125	125	229	24
25	BATHTUB RENOVATIONS	2001	1,150		20	58	58	102	25
26	ROOFING	2001	1,980		20	99	99	165	26
27	ELECTRICAL WORK	2001	2,720		20	136	136	227	27
28	AIR CONDITIONERS	2001	2,702		20	135	135	225	28
29	AIR CONDITIONERS	2001	1,771		20	89	89	126	29
30	TILING	2001	1,263		20	63	63	84	30
31	PAINTING	2001	385		20	19	19	38	31
32	PAINTING, WALLPAPER	2002	16,661		20	16,661	16,661	16,661	32
33	HOT WATER HEATER	2002	34,151		20	1,992	1,992	1,992	33
34	TOTAL (lines 1 thru 33)		$ 2,617,160	$ 59,235		$ 117,593	$ 58,358	$ 907,708	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BRYN MAWR CARE INC. # 0035618 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 2,617,160	$ 59,235		$ 117,593	$ 58,358	$ 907,708	1
2	EXT FACADE	2002	639,615		20	5,330	5,330	5,330	2
3	CARPETING	2002	664		20	33	33	33	3
4	WALL SURROUND PANELS	2002	968		20	48	48	48	4
5	SEWER LINE REPAIR	2002	4,200		20	210	210	210	5
6	BATHTUBS	2002	1,150		20	58	58	58	6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,263,757	$ 59,235		$ 123,272	$ 64,037	$ 913,387	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BRYN MAWR CARE INC. # 0035618 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 3,263,757	$ 59,235		$ 123,272	$ 64,037	$ 913,387	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,263,757	$ 59,235		$ 123,272	$ 64,037	$ 913,387	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BRYN MAWR CARE INC. # 0035618 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 3,263,757	$ 59,235		$ 123,272	$ 64,037	$ 913,387	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,263,757	$ 59,235		$ 123,272	$ 64,037	$ 913,387	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BRYN MAWR CARE INC. # 0035618 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 3,263,757	$ 59,235		$ 123,272	$ 64,037	$ 913,387	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
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20									20
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,263,757	$ 59,235		$ 123,272	$ 64,037	$ 913,387	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BRYN MAWR CARE INC. # 0035618 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 3,263,757	$ 59,235		$ 123,272	$ 64,037	$ 913,387	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,263,757	$ 59,235		$ 123,272	$ 64,037	$ 913,387	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BRYN MAWR CARE INC. # 0035618 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 3,263,757	$ 59,235		$ 123,272	$ 64,037	$ 913,387	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,263,757	$ 59,235		$ 123,272	$ 64,037	$ 913,387	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BRYN MAWR CARE INC. # 0035618 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 3,263,757	$ 59,235		$ 123,272	$ 64,037	$ 913,387	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,263,757	$ 59,235		$ 123,272	$ 64,037	$ 913,387	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BRYN MAWR CARE INC. # 0035618 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		$ 3,263,757	$ 59,235		$ 123,272	$ 64,037	$ 913,387	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,263,757	$ 59,235		$ 123,272	$ 64,037	$ 913,387	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BRYN MAWR CARE INC. # 0035618 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		$ 3,263,757	$ 59,235		$ 123,272	$ 64,037	$ 913,387	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,263,757	$ 59,235		$ 123,272	$ 64,037	$ 913,387	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BRYN MAWR CARE INC. # 0035618 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			1993		$ 25,864	$ 821	35	$ 739	$ (82)	$ 7,020	4
5			1993		12,522	398	35	358	(40)	3,399	5
6											6
7											7
8											8
	Improvement Type**										
9	Allocation Preferred Bookkeeping			1997	15,638	350	20	782	432	4,542	9
10	Allocation Preferred Bookkeeping			1999	124		20	6	6	22	10
11	Allocation Preferred Bookkeeping			2000	784		20	39	39	95	11
12											12
13	Allocation SIR Management			1993	11,108	309	20	560	251	5,499	13
14	Allocation SIR Management			1994	35		20	3	3	29	14
15	Allocation SIR Management			1995	254		20	13	13	94	15
16	Allocation SIR Management			1999	1,207	41	20	60	19	194	16
17	Allocation SIR Management			2000	728	76	20	36	(40)	98	17
18											18
19	Allocation SIR Properties-SIR Management			2002	102		20	3	3	3	19
20	Allocation SIR Properties-SIR Management			1999	3,277	328	20	164	(164)	574	20
21	Allocation SIR Properties-SIR Management			1998	1,566	157	20	78	(79)	352	21
22	Allocation SIR Properties-SIR Management			1997	97	10	20	5	(5)	32	22
23	Allocation SIR Properties-SIR Management			1994	246	6	20	12	6	105	23
24	Allocation SIR Properties-SIR Management			1993	419	12	20	21	9	199	24
25											25
26	Allocation SIR Properties-Preferred Bookkeeping			2002	50		20	1	1	1	26
27	Allocation SIR Properties-Preferred Bookkeeping			1999	1,587	159	20	79	(80)	278	27
28	Allocation SIR Properties-Preferred Bookkeeping			1998	758	76	20	38	(38)	171	28
29	Allocation SIR Properties-Preferred Bookkeeping			1997	47	5	20	2	(3)	15	29
30	Allocation SIR Properties-Preferred Bookkeeping			1994	119	3	20	6	3	51	30
31	Allocation SIR Properties-Preferred Bookkeeping			1993	203	6	20	10	4	97	31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-REP, Line 70 for total

Facility Name & ID Number BRYN MAWR CARE INC. # 0035618 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 76,735	$ 2,757		$ 3,015	$ 258	$ 22,870	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BRYN MAWR CARE INC. # 0035618 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 360,546	$ 45,631	$ 34,784	$ (10,847)	10	$ 209,886	71
72	Current Year Purchases	13,110		1,311	1,311	10	1,311	72
73	Fully Depreciated Assets	202,195				10	202,195	73
74								74
75	TOTALS	$ 575,851	$ 45,631	$ 36,095	$ (9,536)		$ 413,392	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		1998 CHEVY VAN	2001	$ 15,436	$ 4,900	$ 1,544	$ (3,356)	5	$ 2,187	76
77										77
78										78
79										79
80	TOTALS			$ 15,436	$ 4,900	$ 1,544	$ (3,356)		$ 2,187	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,918,114	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 109,766	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 160,911	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 51,145	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,328,966	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

SEE ACCOUNTANTS' COMPILATION REPORT

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number BRYN MAWR CARE INC. # 0035618 Report Period Beginning: 01/01/02 Ending: 12/31/02

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 12,574 Description: See Attached Schedule
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BRYN MAWR CARE INC. # 0035618 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

			1	2	3	4
			Facility			
			Drop-outs	Completed	Contract	Total
1	Community College Tuition		$	$	$	$
2	Books and Supplies					
3	Classroom Wages	(a)				
4	Clinical Wages	(b)				
5	In-House Trainer Wages	(c)				
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests					
9	TOTALS		$	$	$	$
10	SUM OF line 9, col. 1 and 2	(e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BRYN MAWR CARE INC. # 0035618 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Supplemental									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BRYN MAWR CARE INC. # 0035618 Report Period Beginning: 01/01/02 Ending: 12/31/02

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/02 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 5,847	$ 7,885	1
2	Cash-Patient Deposits	21,868	21,868	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	996,091	996,091	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	11,901	11,901	6
7	Other Prepaid Expenses	1,093	1,093	7
8	Accounts Receivable (owners or related parties)	315,000	315,000	8
9	Other(specify): See Supplemental Schedule	32,034	32,034	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,383,834	$ 1,385,872	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		207,475	13
14	Buildings, at Historical Cost		1,443,623	14
15	Leasehold Improvements, at Historical Cost	1,321,375	1,321,375	15
16	Equipment, at Historical Cost	901,787	901,787	16
17	Accumulated Depreciation (book methods)	(931,472)	(1,629,875)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Supplemental Schedule	3,625	47,430	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,295,315	$ 2,291,815	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,679,149	$ 3,677,687	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 352,182	$ 352,182	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	25,833	25,833	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	120,123	120,123	30
31	Accrued Taxes Payable (excluding real estate taxes)	10,084	10,084	31
32	Accrued Real Estate Taxes(Sch.IX-B)	106,500	106,500	32
33	Accrued Interest Payable		23,968	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	28,500	28,500	35
	Other Current Liabilities(specify):			
36	See Supplemental Schedule	57,082	57,082	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 700,304	$ 724,272	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		4,728,212	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Supplemental Schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 4,728,212	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 700,304	$ 5,452,484	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,978,845	$ (1,774,797)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,679,149	$ 3,677,687	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number BRYN MAWR CARE INC. # 0035618 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,553,037	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,553,037	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	1,052,208	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	(626,400)	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 425,808	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,978,845	24	*

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BRYN MAWR CARE INC. # 0035618 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,050,438	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,050,438	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	15,522	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 15,522	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	1,754	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,754	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,067,714	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	749,552	31
32	Health Care	1,332,204	32
33	General Administration	1,083,861	33
	B. Capital Expense		
34	Ownership	754,624	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	95,265	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,015,506	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,052,208	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,052,208	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** Cash Basis **If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number BRYN MAWR CARE INC. # 0035618 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,032	2,152	$ 65,842	$ 30.60	1
2	Assistant Director of Nursing	1,926	2,138	43,070	20.14	2
3	Registered Nurses	1,406	1,406	30,655	21.80	3
4	Licensed Practical Nurses	11,236	12,076	200,584	16.61	4
5	Nurse Aides & Orderlies	52,960	56,117	457,667	8.16	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,957	3,075	29,589	9.62	8
9	Activity Director	1,759	2,087	24,914	11.94	9
10	Activity Assistants	11,309	12,277	96,550	7.86	10
11	Social Service Workers	12,716	13,757	210,757	15.32	11
12	Dietician					12
13	Food Service Supervisor	1,724	1,966	27,014	13.74	13
14	Head Cook	3,327	3,505	31,870	9.09	14
15	Cook Helpers/Assistants	9,846	11,030	77,646	7.04	15
16	Dishwashers					16
17	Maintenance Workers	1,823	2,086	42,051	20.16	17
18	Housekeepers	14,315	15,244	107,221	7.03	18
19	Laundry					19
20	Administrator	1,870	2,086	69,163	33.16	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,198	4,716	58,341	12.37	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,386	2,698	38,943	14.43	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental					33
34	TOTAL (lines 1 - 33)	137,790	148,416	$ 1,611,877 *	$ 10.86	34

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 29,748	01-03	35
36	Medical Director	Monthly	2,400	09-03	36
37	Medical Records Consultant	96	4,128	10-03	37
38	Nurse Consultant		34,452	10-03	38
39	Pharmacist Consultant	Monthly	1,440	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	43	2,033	11-03	44
45	Social Service Consultant				45
46	Other(specify)				46
47	Consultant Specialized Rehab.	Monthly	15,456	10a-03	47
48	Psychiatric Director Consultant	Monthly	1,800	12-03	48
49	TOTAL (lines 35 - 48)	139	$ 91,457		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	1,138	$ 42,338	10-03	50
51	Licensed Practical Nurses				51
52	Nurse Aides	307	6,057	10-03	52
53	TOTAL (lines 50 - 52)	1,445	$ 48,395		53

Facility Name & ID Number BRYN MAWR CARE INC. # 0035618 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Augusto Beley	Adminastrator	0	$ 69,163
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 69,163

B. Administrative - Other

Description	Amount
Management Fees - SIR Management	$ 266,386
Director of Administrative Services-SIR Management	21,924
Ancillary Administrative Charges-SIR Management	39,144
Owners Council Dues - See Attached	21,600
TOTAL (agree to Schedule V, line 17, col. 3)	$ 349,054
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Preferred Bookkeeping	Accounting	$ 28,900
Frost, Ruttenberg & Rothblatt	Accounting	14,125
Personnel Planners	Unemployment Tax Con.	900
Preferred Bookkeeping	Bookkeeping	54,288
Preferred Bookkeeping	Computer Services	4,176
SIR Management	Director of Regulatory Svcs	14,100
ICS Solutions	Website	135
Art Rousseau	Directors Fees	400
ProClaim America	Third Party Ins. Set Up Fee	222
LTC Solutions	Software Support	1,320
Michael Best & Friedrich	Legal	17,691
SIR Management, Inc.	Legal	6,264
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 142,521

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 14,610
Unemployment Compensation Insurance	19,497
FICA Taxes	120,913
Employee Health Insurance	62,953
Employee Meals	14,053
Illinois Municipal Retirement Fund (IMRF)*	
Chicago Head Tax	3,960
Union Health & Welfare	48,944
401K	600
Other Employee Benefits	3,766
TOTAL (agree to Schedule V, line 22, col.8)	$ 289,296

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	4,232
Health Care Worker Background Check	306
(Indicate # of checks performed 48)	
Dues & Subscriptions	6,201
License & Permits	3,056
Allocation-Preferred	179
Allocation-SIR Mgmt.	17
Allocation-ECM	20
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 14,011

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,236
Allocation-Preferred	35
Allocation-SIR Mgmt.	203
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,474

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number BRYN MAWR CARE INC. # 0035618 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BRYN MAWR CARE INC. # 0035618 Report Period Beginning: 01/01/02 Ending: 12/31/02

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IL Council on Long Term Care $8926**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **1,159** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **95,265**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **N/A**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **14,053** Has any meal income been offset against related costs? **No** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **100%ln14**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees